Improving Care Delivery for Children: Leveraging the Medicaid Benefit for Children and Adolescents

Wednesday, February 5, 2014
3:00 – 4:30 pm ET

For audio, please listen through your speakers or call:
800-732-6870

Supported by the Centers for Medicare & Medicaid Services under a contract to NORC at the University of Chicago

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

• Mandatory for all children <21 enrolled in Medicaid

• EPSDT covers:
  • Periodic screening—including mental health/substance use disorder screening
  • Diagnosis and Treatment, including services not otherwise covered by a state’s Medicaid program
  • Services needed to support access
# Agenda

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<th>Time</th>
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| 3:00 – 3:05 pm | Welcome and Introductions  
Neva Kaye, Managing Director for Health System Performance, NASHP |
| 3:05 – 3:15 pm | Federal Perspective on the Medicaid Benefit for Children and Adolescents  
Eliot Fishman, Director of the Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services |
| 3:15 – 3:20 pm | New Resources for States  
Neva Kaye |
| 3:20 – 4:00 pm | Insights from States  
Glenace Edwall, Director of the Children's Mental Health Division of Minnesota's Department of Human Services  
Colleen Sonosky, Associate Director of the D.C. Department of Health Care Finance  
Jennifer Vermeer, Medicaid Director, Iowa Department of Human Services |
| 4:00 – 4:25 pm | Question and Answer  
Facilitator: Neva Kaye |
| 4:25 – 4:30 pm | Wrap-up |

## A Federal Perspective on the Medicaid Benefit for Children and Adolescents

**Eliot Fishman, Ph. D.**  
Director of the Children and Adults Health Programs Group (CAHPG)  
Center for Medicaid and CHIP Services (CMCS)  
Centers for Medicare & Medicaid Services
New Resources for States

- NASHP has launched a new Resources to Improve Medicaid for Children and Adolescents map: http://www.nashp.org/epsdt/resources-improve-medicaid-children-and-adolescents

- The map offers:
  - **State-specific resources** on several topics, including data collection, care coordination, and behavioral health
  - **Strategies** that state policymakers and Medicaid officials are using to deliver the Medicaid benefit for children and adolescents
  - Additional national resources
Minnesotan

How has Minnesota’s emphasis and approach to providing behavioral health services to children shifted in recent years?

Behavioral Health Services for Children in Minnesota

Minnesota's emphasis and approach to providing behavioral health services to children has shifted in recent years:

• Moving to earlier identification and earlier, effective interventions, based on family input
• Using framework of developmental trajectories to conceptualize needs, including effects of stress and trauma; for children, recovery a component of resilience. Replaces behavior control orientation.
Behavioral Health Services for Children in Minnesota (cont.)

• Incorporating behavioral health in prevention and health promotion: screening for developmental, socioemotional/mental health and maternal depression at well-child checks (Minnesota’s use of EPSDT for Child & Teen Check-Ups)

How has Minnesota leveraged the EPSDT benefit and the Medicaid State Plan to cover the continuum of services required by children with complex needs?
Leveraging the EPSDT Benefit in Minnesota

Covering the continuum of services required by children with complex needs:

• Broad stakeholder agreement on “model” benefit set, progressively enacted
• Create enough flexibility in basic benefits (diagnostic assessment, psychotherapy, Children’s Therapeutic Services and Supports) to allow application to different developmental stages and magnitude of need

Leveraging the EPSDT Benefit in Minnesota (cont.)

• Goal of diverse service array as complexity of needs increases to have right services available at the right time and place
  o Examples: flexible use of CTSS; additions of Youth ACT and Intensive Supports for Foster Care
• Meaningful use of rehabilitation option to address impact of behavioral health conditions on developmental trajectories
Leveraging the EPSDT Benefit in Minnesota (cont.)

Examples: ADHD may create 25% lag in socioemotional development, exacerbating social and educational problems; many common children’s mental health disorders accompanied by disruptions in development of social, communication and self-regulation capabilities

• CTSS skills training pairs rehabilitative goals with psychotherapeutic reduction of core symptoms and their sequelae

Visit Minnesota’s page on NASHP’s new resource compendium to learn more: http://www.nashp.org/epsdt/minnesota

You will find materials including links to:

• A vignette of behavioral health services available to children in Minnesota
• Resources on care coordination strategies like medical homes and new “Accountable Communities for Health” that affect children
• Forms and training modules produced by the state to help primary care providers understand topics including developmental screenings

…and much more!
District of Columbia

The District has a long history of working to improve data collection and reporting on well-child care. Where has that focus led you?

Children’s Health Coverage in DC

- **Insurance Coverage & Medicaid/CHIP Participation**
  - *Low Numbers of Uninsured*: Only 3% of DC children lack health care coverage; enrollment of children in Medicaid/CHIP increased by 13% from 2008-2010.
  - *High Participation Rate in Public Insurance*: In FY11, about 95% of eligible children were enrolled in Medicaid/CHIP according to Urban Institute figures.

- **Medicaid/CHIP Enrollment Overview**
  - FY12 CMS 416: 97,000 children were enrolled in DC Medicaid/CHIP at some point during year
  - About 70% of the District’s children are enrolled in Medicaid/CHIP
  - Over 40% of D.C. Medicaid enrollees are children

- **Service Delivery for Pediatric Care under Medicaid**
  - All beneficiaries under 21 receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services benefit through Managed Care or Fee-for-Service
Defining the Problem of Documenting Well-Child visits

- A well-child visit should include all components as described on the District’s periodicity schedule (following AAP guidance)
- Providers currently use general preventive visit or evaluation and monitoring procedure codes to bill well-child visits.
- This current billing practice does not allow DHCF to:
  - confirm that all components were performed;
  - prepare detailed analyses on any one component (e.g., developmental or mental health screen); and
  - detail need for diagnostic or treatment services.

Improving Data Collection & Reporting on Children’s Health

- Meeting Coverage Goals: Crossing the Finish Line for Children’s Health Coverage
- Utilization of Services
  - Documenting Well-Child Visits and Referrals
  - Defining and Quantifying the “T” in EPSDT
- Quality of Care
  - Use of HEDIS: Core Measures & Measurement Development
- Outcomes
  - Defining Outcome Measures to tell story of children’s health well-being in your state
- Need for Good Data when Communicating with Key Stakeholders in Defining Child Health Goals:
  - Policymakers (Executive and Legislative branches)
  - MCO & Provider Communities
  - Other Child-Serving Agencies Coordinating with the Medicaid Agency
  - Families Served by Medicaid program
What have been the key components of your strategy to address the issues with tracking service delivery to children you identified (e.g., at the provider level, or around changes in billing)?

FY2014 Children’s Health Focus Areas

- Improving Billing Procedures for Well-Child Visits: Integrating Primary Care with Developmental, Behavioral, and Oral Health Care
  - Develop well-child visit coding/billing with reporting requirements for all screening components & documentation
  - FY14 Implementation of PCP billing for Fluoride Varnish
  - Outreach & Education on Pediatric Oral Health Care

- Coordinating Primary Care and Behavioral Health Services
  - DC Collaborative for Mental Health in Pediatric Primary Care
  - Integrating well-child care and behavioral health assessments

- School Health & Service Coordination
  - Data Sharing and targeted service delivery for health services to school-aged children

- Develop comprehensive picture of FFS pediatric population
  - High-cost beneficiaries, zero-use beneficiaries, most frequent conditions, etc.
Integrating Primary Care with Developmental, Behavioral & Oral Health

- Coordinating Major Initiatives for Children in DC
  - DC Pediatric Oral Health Coalition & Fluoride Varnish implementation
  - DC Collaborative for Mental Health in Pediatric Primary Care (Partnership with Children’s National Health System (CN), Georgetown, Dept. of Behavioral Health (DBH), DHCF and Children’s Law Center)
    - Includes SAMHSA funded projects with DBH (System of Care & Project Launch)
  - Help Me Grow (Department of Health)
  - Mayoral Initiatives: Raise DC & Early Success Council (includes goals related to measuring developmental screens)

DC Collaborative for Mental Health in Pediatric Primary Care

- Multi-faceted project (provider, advocacy and government agency partnership) involving the following:
  - Surveys of Providers: Primary Care and Mental Health
  - Mental health screening tools recommendations to DHCF for pediatric primary care providers
  - Develop electronic tool-kits for pediatric practices
  - CN Quality Improvement Learning Collaborative to train pediatricians on mental health screening and referrals
  - Development of Child Behavioral Health Access program for pediatric practices to have direct linkages to psychiatric consults (drawn from Massachusetts Psych Access Project)
Medicaid Benefit Delivery

DC Medicaid’s Service Delivery Systems:
- Managed Care [approximately 90% of Medicaid children]
  - AmeriHealth DC
  - MedStarFamily Choice
  - Trusted Health Plan
  - Health Services for Children with Special Needs (for disabled children up to age 26)
- Fee-for-Service [approximately 10% of Medicaid children]
  - Children with Disabilities not residing in an institution
  - Children residing in LTC facilities
  - DYRS-linked children
  - Children under custody of Child & Family Services Agency (foster care, adopted)
- Provider Types Serving Children in the District of Columbia
  - FQHCs (e.g., Unity, Mary’s Center)
  - Facility-Based (e.g., Children’s National Health System, Georgetown)
  - Provider Practice Groups
  - Public Providers (enrolled as Medicaid providers)

The District also has a long-standing managed care program. How have you worked with managed care organizations (MCOs) to improve quality and delivery of EPDST services?
Partnering with MCOs to Improve Service Delivery of EPSDT through Provider Education

- **Primary Care Provider Education**
  - HealthCheck Training & Resource Center: [http://www.dchealthcheck.net/index.html](http://www.dchealthcheck.net/index.html)
  - Materials on Medicaid’s EPSDT Benefit for DC Providers, Government Agencies and Families
  - EPSDT training (for 5 CMEs paid by MCOs every two years) and Fluoride Varnish Training for PCPs to serve children 0-3
  - Based on Bright Futures Guidelines with latest materials and guidances from CMS, HRSA, and national organizations
  - Compliance of provider training monitored by DHCF and MCOs

Visit the District of Columbia’s page on NASHP’s new resource compendium to learn more: [http://www.nashp.org/epsdt/dc](http://www.nashp.org/epsdt/dc)

You will find materials including links to:

- Managed care **contract language** on behavioral health and care coordination
- **New codes** for oral health assessments for young children and topical application of fluoride varnish
- **Resources** for Medicaid beneficiaries, primary care providers, and other stakeholders to better understand the Medicaid benefit for children and adolescents

…and much more!
How is Minnesota leveraging evidence-based practices and using data to look at outcomes for children?

Leveraging Evidence-Based Practices and Data in Minnesota

Evidence-based practice strategies:
• Core strategy is widespread training (and moving toward certification) on practice elements approach, so that intervention generalists have toolkit to match each child’s needs with research base on what works [thanks to Bruce Chorpita, Ph.D., and Eric Daleiden, Ph.D.]
Leveraging Evidence-Based Practices and Data in Minnesota (cont.)

- Additional training and certification statewide for most substantial system-wide issues: trauma and early childhood needs
  - Examples: Trauma-Focused Cognitive Behavioral Therapy; set of early childhood interventions including Incredible Years, Parent Child Interaction Therapy, Minding the Baby, Trauma-Informed Child-Parent Psychotherapy

Leveraging Evidence-Based Practices and Data in Minnesota (cont.)

- Using data:
  - Creation of dashboards in conjunction with practice elements to track target issues, interventions, outcomes
  - Working toward uniformity in instrumentation to assess risks (screening instruments), strengths and needs in designing intervention (SDQ), and service intensity needs (CASII and ECSII)
What’s an aspect of your service delivery for children that you feel is a particularly big accomplishment for your state?

Iowa

• Children/youth with serious emotional disturbances (SED)
  • A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet DSM diagnostic criteria
  • Results in functional impairment
  • ~16,000 children/youth potentially eligible as identified through Magellan claims information
Strength: IHH Team
Roles & Responsibilities

**Magellan**
- Selects IHH providers
- Provides care management support through
  - Claims-based reporting to identify gaps in care
  - Risk analysis
  - Development of online tools to support daily service delivery and population management needs

**Community IHH Provider**
- Develops care teams to work with members
- Uses data and technology to oversee and intervene in the total care of the member
- Works with community services and supports to address member/family needs
- Develops whole-health approaches for care

Strength
Pediatric - Integrated Health Home
Technical Assistance from CHSCs

- Develop curriculum
- Prepare 20 P-IHH sites
- Conduct practice readiness assessments
- Facilitate virtual and onsite TA sessions (program development and implementation)
- Develop learning networks
- Data collection/performance assessment (analyze patient, family practice data)
- Practice transformation coaching
- Continuous mentoring
What can Pediatric IHH do?

- Family-centered, strengths-based approach
- Care coordination using wraparound approach
- Team Approach
  - Health promotion
  - Individual and family support services
  - Referral to community and social support services
  - Transitional Care, Comprehensive Care Management

Team Approach

The Integrated Health Home (IHH) is not a place.
- The IHH is a service delivery model designed to utilize a team
- They have a set of unique skills based on their experiences and education.
- All work together for the member and family
- Wraparound services for better care

Care Coordination
Health and Wellness Education
Resource Direction
Family Support Services
Transitional Care Support
Wraparound Principles taught to P-IHH providers

- Family voice and choice
- Team based
- Natural supports
- Collaboration
- Community-based
- Culturally competent

- Individualized
- Strengths based
- Persistence
- Outcome based

Why System of Care Approach?
Iowa’s SOC Program Proved Effective

- Parent perception of child’s functioning **improved from 33% at baseline to 58%**
- School attendance increased
- Criminal justice involvement decreased
- Social connectedness improved

Number of Out-of-Homes Placements Avoided:

- DHS Child Welfare 267
- Juvenile court 232
- Out of home placement 152
- Involuntary commit to 122
### Characteristics of Systems of Care

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<tbody>
<tr>
<td>Fragmented service delivery</td>
<td>Coordinated service delivery</td>
</tr>
<tr>
<td>Categorical programs</td>
<td>Blended resources</td>
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<tr>
<td>Limited services</td>
<td>Comprehensive service array</td>
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<tr>
<td>Reactive, crisis-oriented</td>
<td>Prevention/early intervention</td>
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<td>“Deep end,” restrictive</td>
<td>Least restrictive settings</td>
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<tr>
<td>Out-of-home placements</td>
<td>Children/youth within families</td>
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<tr>
<td>Centralized authority</td>
<td>Community-based ownership</td>
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<tr>
<td>Creation of “dependency”</td>
<td>Creation of “self-help”</td>
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**Iowa**

**How did you get to this point? How did these partnerships with Title V develop and how does this relate to the EPSDT benefit?**
Iowa’s Title V Program

- Shared between the Iowa Department of Public Health and Child Health Specialty Clinics (for children with special needs)
- Both provide care coordination under the EPSDT program.
- CHSC assisted with implementation of SAMHSA SOC award.
- IDPH/CHCS Partnership springboards into IHH Program

In moving forward with this initiative, what were some of the challenges in making the health home work for this population of children?
Phase 1:
5 Counties, 9 P-IHHs
Started July 1, 2013

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<th>Actively Engaged Members</th>
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<td>3,535</td>
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Lessons Learned:
- Fully engaging members and families has proven time and resource intensive.
- Under Section 2703, there are barriers to developing a child-specific program. The law forbid states to exclude populations by age.

Visit Iowa’s page on NASHP’s new resource compendium to learn more: [http://www.nashp.org/epsdt/iowa](http://www.nashp.org/epsdt/iowa)

You will find materials including links to:
- A handbook on care coordination for EPSDT Care for Kids Coordinators in the public health department
- Health Homes Medicaid state plan amendment language
- Behavioral health resources like behavioral health providers manuals, behavioral health organization contract language, and a vignette of behavioral health service delivery in Iowa

...and much more!
Questions and Answers

Questions for the presenters?
Please type them into the chat box now!
Thank You!

Please fill out your evaluations!

For additional resources, Visit nashp.org/epsdt/resources-improve-medicaid-children-and-adolescents